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NAVIGATING THE ERA OF ACCOUNTABLE CARE ORGANIZATIONS (ACOs):
A strategic planning guide

Healthcare institutions striving for long-term growth have a new and evolving care model with which to contend: the Accountable Care Organization (ACO). While many consider ACOs the front line of healthcare reform, others believe the concept faces an uphill battle for viability. Regardless, the ACO has become a dynamic factor that must be addressed by physicians, hospitals, health systems and others as they map out strategic organizational direction.

Tactical planning is the key to securing both short-term and long-range competitive advantage as ACOs—as well as other models of population healthcare—begin to proliferate. Successful preparation will require:

- an understanding of the history behind ACO development;
- insight into why ACOs now are gaining favor;
- acknowledgement of the challenges inherent in the ACO model;
- appreciation for the overarching goals of the ACO model; and
- clear strategies for moving toward clinical/organizational integration.

Historical perspective

At the root of most current healthcare reform initiatives is the desire to restrain costs while simultaneously improving patient outcomes. The ACO care model is designed to provide an alternative to existing fee-for-service reimbursement by encouraging care coordination among providers across all healthcare settings. It is a Medicare initiative initially referenced in the American Recovery and Reinvestment Act of 2009 (ARRA) and more distinctly described in the Patient Protection and Affordable Care Act of 2010 (PPACA). PPACA, in fact, mandates that Medicare test the efficacy of ACOs through pilot projects.

As an integrated care and reimbursement model, the ACO strives to hold providers accountable for both the cost and quality of care delivered to a given patient population. According to Medicare, an ACO is "an organization of health care providers that agrees to be accountable for the quality, cost, and overall care of Medicare beneficiaries who are enrolled in the traditional fee-for-service program who are assigned to it. For ACO purposes, 'assigned' means those beneficiaries for whom the professionals in the ACO provide the bulk of primary care services…"[1]

[1] Medicare "Accountable Care Organizations" Shared Savings Program – New Section 1899 of Title XVIII, Preliminary Questions & Answers, CMS/Office of Legislation, http://www.cms.gov/OfficeofLegislation/Downloads/AccountableCareOrganization.pdf

Many have rather erroneously compared ACOs to health maintenance organizations (HMOs), but it is important to understand that there are distinct differences between the two. In many HMO arrangements, for instance, payers have more incentive to keep costs low than to improve patient care quality. The ACO seeks to adjust this imbalance by holding providers accountable for both aspects; providers will need to achieve specific quality metrics before they will be able to earn reimbursement.

ACOs also will not be allowed to control patient access to providers—the so-called "gatekeeper" method used by many HMOs. Medicare states, "Assignment will be invisible to the beneficiary, and will not affect their guaranteed benefits or choice of doctor. A beneficiary may continue to seek services from the physicians and other providers of their choice, whether or not the physician or provider is a part of an ACO." [2]

In reality, the transformative principle behind ACOs is the firm establishment of patients at the center of all healthcare decisions. Patient data is the tool used to support shared responsibility across the continuum of care, shifting focus away from acute, episodic care delivery toward more preventive and population-based approaches. With this shift, the ACO marks a transition from traditional fee-for-service reimbursement to newer "value-based" purchasing models.

Challenges ahead

Despite the benefits suggested by more patient-centric and preventive care methodologies, ACOs clearly will pose some unique hurdles for the entire healthcare industry. Chief among them will be:

1. assessing information technology (IT) infrastructure needs;

2. formalizing meaningful hospital/physician strategic partnerships; and

3. restructuring traditional cultural paradigms.

Much debate currently centers on how to build a cohesive IT infrastructure that will enable more efficient, collaborative patient care. The ACO is among several initiatives that advocate enhancing care quality by using real-time, comparative data analysis to establish "best practices (evidence based medicine)." Cost reduction, meanwhile, also is expected to be achieved through better access to data at the point of care. Providers able to access a complete, longitudinal patient record can help eliminate unnecessary duplicate tests and services, as well as reduce the need for acute care services through collaborative preventive measures.

Tools and processes that promote cost and quality reporting, evidence-based medicine, and care coordination are requisite. Electronic health records (EHRs), practice management systems, disease registries, and various analytic tools all play a role in the ACO, but at this point in time only a few healthcare organizations can boast sophisticated use of these resources.

The arrival of the ACO therefore compels an investment in IT systems capable of measuring, reporting, and evaluating patient care processes—not just within organizations, but across the spectrum of healthcare providers and settings. Population healthcare management begins with the use of IT.

Still, the greater challenge is likely to be encountered as organizations try to change their missions, values, operations and workflows to reflect these new industry realities. For example, how will practices build compensation incentives based on measured patient outcomes rather than the number of services rendered? How will organizations strengthen inter-institutional relationships that in the past may have been competitive—or even adversarial?

None of these challenges is slight or without consequence. Yet it is possible to master them by first laying a foundation of meaningful governance, then establishing four pillars of support.

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[2] Ibid

Setting the foundation: Joint, meaningful governance

The legislation that introduced ACOs offers few specifics to help guide the formation of a governance structure. In fact, the little that lawmakers have spelled out about organizational alignment is very broad in nature. What is clear is that ACOs should have:

- a formal legal structure to receive and distribute shared savings;
- enough primary care professionals for at least 5,000 assigned beneficiaries;
- enough information about participating ACO professionals to support beneficiary assignment and to determine shared savings payments; and
- a leadership and management structure that includes clinical and administrative systems.[3]

Lawmakers otherwise have left the door open for healthcare entities to determine their own best ACO configurations. Consequently, creating a thriving ACO will require each organization to craft a strategic plan appropriate to its own unique corporate culture and goals. Success will depend on adhering to the adage, "Culture trumps strategy."

For example: Deciding whether physicians should be in ownership roles or advisory roles within an ACO will be dictated largely by the relationship and corporate cultures of the parties involved. But regardless of the governance model used, it must empower each party to leverage the relationship to enhance patient care. Typically, this will require the meaningful engagement of physicians in decision-making.

Many past attempts at healthcare integration failed primarily because physicians were alienated from significant decision-making processes. To avoid this pitfall, shared management responsibility is essential. Clinicians must be involved—not only in practice operations, but also in setting the future course of the ACO itself.

All decisions also must be made in the spirit of collaboration, with the goals of each partner in mind. Policies and procedures should be created that foster forward-thinking relationships between the hospitals, physicians, and any other organizations encompassed within an ACO.

Ensuring a physician-led, professionally managed ACO is one of the best ways to accomplish these goals. While physicians must step into bona fide leadership roles, that fact does not necessarily mean appointing a physician as CEO, for example. Instead, many ACOs will be well-served by the use of a management services organization (MSO) or other group that exists outside of competing partisan interests. A neutral third-party management group allows physicians and administrators to more objectively steer the direction of the ACO as a whole.

The four pillars of a successful ACO

Building positive relationships among healthcare organizations that have had little reason to cooperate in the past is always a difficult task. Yet in almost every situation, identifying shared needs can serve to bridge the divide. Organizations can start with the four elements every ACO must include:

1. informatics
2. clinical integration
3. financial management
4. care coordination

Each of these four "pillars" presents an opportunity for organizations to move toward clinical/organizational integration. The first step toward encouraging the equal engagement of all parties in ACO governance is to address informatics.

Pillar #1: Creating a relationship around informatics. Informatics is a natural starting point for discussions between hospitals and physicians, simply because it is the platform upon which evidence-based medicine typically is built. Using technology to better serve patients is a

[3] Ibid

universal focus. But before data can be shared in a meaningful way, healthcare providers understand they must first shape an IT infrastructure that works equally well for all parties. Organizations need to evaluate a core vendor vs. interfaced best-of-breed application strategy, to ensure they have advanced reporting capabilities and the critical ability to exchange information between ambulatory and inpatient applications.

Pillar #2: Moving toward clinical integration.
Clinical integration typically flows from IT infrastructure, based on the premise that making data available across the continuum of care will enhance care. That is why the ACO model relies so heavily on use of the EHR to gather and analyze care quality data. Determining which "best practices" genuinely enhance patient outcomes requires vigorous data tracking, trending and benchmarking. But the more patients experience improved evidence-based outcomes, the more the industry will move toward fostering population-based wellness instead of individual, episodic treatments.

Pillar #3: Redefining financial management.
Those who back the ACO model firmly believe that evidence-based "best practices" will lead to lower costs in two distinct ways. First is the emphasis on preventive care instead of more-costly acute care. Second is the hope that when all providers have access to the entire patient record at the point of care, they will be able to avoid unnecessary duplicate diagnostic tests and services. However, most industry experts agree that the reimbursement aspect of the ACO poses one of its most difficult challenges. Success is dependent, in part, on hospitals and physicians aligning to push commercial health plans toward "accountable" reimbursement structures.

Pillar #4: Achieving care coordination.
Truly patient-centric care coordination is the ultimate goal of the ACO model. All three previous elements—establishing an informatics relationship, moving toward clinical integration, and setting "accountable" financial incentives—are necessary components of coordinated, patient-centric care.

Embracing the future of healthcare

Most healthcare experts agree that the status quo is not sustainable. Integrated care concepts designed to rein in costs and improve patient outcomes are shaping the direction of national healthcare policy. An environment of mutual respect and collaboration is beginning to take hold.

There is a growing recognition of the power of data to help unite hospitals, physician groups, payers and other providers toward more accountable patient care. Healthcare organizations, therefore, must begin to chart a course for more data-enriched and coordinated care delivery systems. The key is the ability to craft collaborative and dynamic strategic plans that successfully master the challenges inherent in an ACO. It is clear that "accountability" already is beginning to transform the entire healthcare experience.

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Culbert Healthcare Solutions
800 West Cummings Park
Suite 6000
Woburn, MA 01801

p: 781-935-1002
f: 781-313-0144

www.culberthealth.com